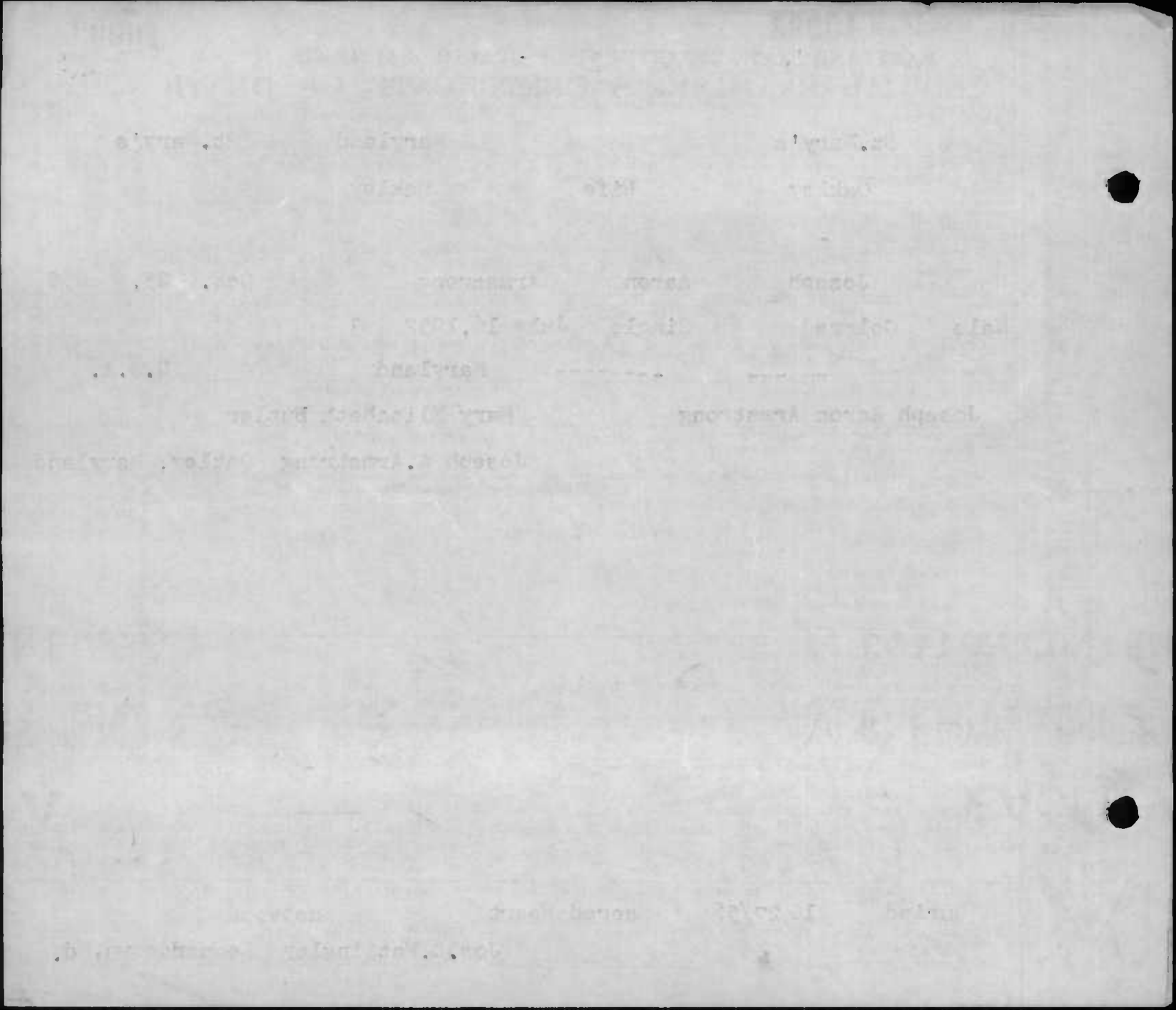


PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10093				10099			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Oakley		Five		TOWN Oakley			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Joseph Aaron Armstrong				Oct. 25, 19 55			
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: July 16, 1952	
9. AGE last birthday: 3 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Joseph Aaron Armstrong				14. MOTHER'S MAIDEN NAME: Mary Elizabeth Butler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: Joseph A. Armstrong Oakley, Maryland			
17. INFORMANT & ADDRESS:							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
204.1 Immediate cause (a)..... Myeloid leukemia DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE SIGNED					
Paul F. Green		10/27/55					
23. BURIAL, CREMATION, REMOVAL (Specify): Buried		DATE THEREOF: 10/27/55		NAME OF CEMETERY OR CREMATORY: Sacred Heart		LOCATION (City, town, or county) (State): Bushwood	
DATE REC'D BY LOCAL REG. 10/25/55		REGISTRAR'S SIGNATURE: C. W. Hedrick		24. FUNERAL DIRECTOR: Jos. C. Mattingley		ADDRESS: Leonardtown, Md.	



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10094

10100

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Leonardtwn		15 day's		TOWN Rural Great Mills			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
St. Mary's Hospital							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
Walter Spencer Bulla				Oct. 25 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	October 26, 1883	#71 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Railroad		Clerk		North Carolina		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Alfred Morton Bulla				Elizabeth Spencer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or none)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		NONE		Spring Valley Park			
		704-16-8427		Mary L. Bulla Great Mills, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Hemorrhage						15 days	
ANTECEDENT CAUSE(S) DUE TO (B) General arteriosclerosis						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 10, 1955 , to Oct 25, 1955 , that I last saw the deceased alive on Oct 25, 1955 , and that death occurred at 11:10 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
M. J. Bulla M.D.				Great Mills Md		10/26/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		10/28/55		Chestnut Hill		Salisbury, North Carolina	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Oct 26/55		M. J. Bulla M.D.		Jos. C. Matthews		Leonardtwn, Md.	

CERTIFICATE OF DEATH

10001

10-1-1965

PLACE OF DEATH

St. Mary's Hospital

MARYLAND

St. Mary's

10001

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10001

St. Mary's Hospital

St. Mary's Hospital

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BUREAU V. S.

OCT 27 1965

RECEIVED

10/28/65

10/28/65

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18				10101	
10095				CERTIFICATE OF DEATH	
Reg. Dist. No.				282	
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>St. Marys</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Compton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Compton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>St. Clements Shores</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Rosevear Chaplin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 - 17 - 19 55</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>November 17, 1902</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Frank J. Chaplin</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Rosevear</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Mollie P. Chaplin - Compton, Maryland.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>200.1 Cachexia, malnutrition</u>					
ANTECEDENT CAUSE(S) DUE TO (B) <u>Lymphosarcoma</u>				<u>18 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 17, 1955</u> to <u>Oct 17, 1955</u> , that I last saw the deceased alive on <u>Oct 17, 1955</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>J Roy Guyther</u>		M.D. <u>Mechanicsville</u>		DATE SIGNED <u>10/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24. REC'D BY REGISTRAR <u>Alan D. Houser</u>		REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE <u>10-19-55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>		ADDRESS	

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© 2006 The Authors

Source: *Author's calculations*.

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BUREAU V. 3

OCT 20 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10096

CERTIFICATE OF DEATH

10102

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN Leonardtwn		1 day		TOWN Rural Charlotte Hall			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Mary's Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) George Francis Dade				4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 19 55			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 30, 1952	9. AGE last birthday 3 yrs.	IF UNDER 1 YEAR Months 5 Days 28		IF UNDER 24 HRS. Hours 28 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Corinilous Dade				14. MOTHER'S MAIDEN NAME Mary E. Barns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Jos. E. Dade Charlotte Hall, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				5 days			
491X IMMEDIATE CAUSE (A) Bilateral Bronchitis (Pneumonia)							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/27 , 19 55 , to 10/25 , 19 55 , that I last saw the deceased alive on 10/27 , 19 55 , and that death occurred at 10/27 M, from the causes and on the date stated above.							
SIGNATURE Richard D. Dade M.D.				ADDRESS (Street, city, town, state) Leonardtwn Md		DATE SIGNED 10/27/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/28/55		NAME OF CEMETERY OR CREMATORY Ebenezer		LOCATION (City, town, or county) (State) Charlotte Hall, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Alan L. Hauser		25. FUNERAL DIRECTOR'S SIGNATURE C. Mattingly		ADDRESS Leonardtwn, Md.	
DATE 10-28-55							

RECORDED

ALL RECORDS OF THE BUREAU OF HEALTH-BALTIMORE, MD.
ARE KEPT IN THE BUREAU OF HEALTH-BALTIMORE, MD.
AND ARE NOT TO BE DESTROYED WITHOUT THE
APPROVAL OF THE BUREAU OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

10096

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

NAME: Mary's Hospital
RESIDENCE: Baltimore
DATE OF DEATH: April 30, 1922
PLACE OF DEATH: Mary's Hospital
CAUSE OF DEATH: ...

AGE: 28
SEX: Female
COLOR: Colored
RELIGION: ...

NAME: Joseph Caroline Bado
RESIDENCE: ...
DATE OF DEATH: ...
PLACE OF DEATH: ...
CAUSE OF DEATH: ...

NAME: Jos... Bado
RESIDENCE: ...
DATE OF DEATH: ...
PLACE OF DEATH: ...
CAUSE OF DEATH: ...

BUREAU V. E.

NOV 1 1925

RECEIVED

Examiner

10/26/22

Initial

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10103

10097

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Wynn</u>		<u>6 yrs.</u>		TOWN <u>Wynn</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>08</u>				<u>Rural</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Estelle</u> (Middle) <u>Cole</u> (Last) <u>Dominy</u>				<u>10 - 21 - 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>married</u>	<u>Aug. 25, 1890</u>	<u>65</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Domestic</u>		<u>Washington, D.C.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles D. Cole</u>				<u>Augusta M. Geisler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>345-07-7142 B</u>		<u>Carl G. Dominy - Wynn, Maryland.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>1 month</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u>						<u>20 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>lobar pneumonia, hyperemia, heart failure</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>none</u>		<u>none</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<u>none</u>		<u>none</u>		<u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>none</u>		<u>none</u>		<u>none</u>			
22. I hereby certify that I attended the deceased from <u>2/10/54</u>, 19<u>54</u>, to <u>10/21</u>, 19<u>55</u>, that I last saw the deceased alive on <u>10/20</u>, 19<u>55</u>, and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John D. Geisler</u>				ADDRESS (Street, city, town, state) <u>Wynn, Maryland</u>			
DATE <u>10/21/55</u>				DATE SIGNED <u>10/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/23/55</u>		<u>Trinity Cemetery</u>		<u>St. Marys City, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Local</u>		<u>P. B. Robinson</u>		<u>P. B. Robinson</u>		<u>Leonardtown, Md.</u>	

10103

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

10095

Form 100-10-10

IN THE COUNTY OF BALTIMORE

DECEASED
NAME
AGE
SEX
RACE
MARRIAGE

MARYLAND
STATE
DEPARTMENT
OF
HEALTH

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
EDUCATION
OCCUPATION
RELIGION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
EDUCATION
OCCUPATION
RELIGION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
EDUCATION
OCCUPATION
RELIGION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
EDUCATION
OCCUPATION
RELIGION

BUREAU V. 2

OCT 24 1955

RECEIVED

10103

10103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 10104
 Reg. Dist.

No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Saint Mary's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Laurel Grove</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Morganza</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>				STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>John</u>		(Middle) <u>Columbus</u>		(Last) <u>HOLT</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>2 / 12 / 12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		9. AGE last birthday: <u>43</u> yrs.		4. DATE OF DEATH <u>October 14</u> , 19 <u>55</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
13. FATHER'S NAME: <u>Philip Holt</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Stewart</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>-----</u>	
17. INFORMANT & ADDRESS: <u>Vilot M. Coates * 309 U St.N.W., Wash. 1, DC</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>Intercranial hemorrhage</u> DUE TO <u>fractured skull</u> Antecedent cause(s) (b) <u>none</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>none</u> stating underlying cause last (c) <u>none</u>				Immediate Immediate			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>				III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDING OF OPERATION: <u>none</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, street, office, etc.) OF INJURY: <u>Laurel Grove, St. Mary's, Md.</u>		21c. (City or town) (County) (State): <u>Laurel Grove, St. Mary's, Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>10 14 55 P.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell off truck & under rear wheel</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <u>[Signature]</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED: <u>10/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10/17/55</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Joseph's Cemetery</u>		LOCATION (City, town, or county) (State): <u>Morganza, Maryland</u>	
DATE REC'D BY LOCAL REG: <u>10 / 17 / 55</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>P. B. Robinson</u>		ADDRESS: <u>Leonardtown, Maryland.</u>	

BUREAU V. S.

OCT 18 1965

RECEIVED

BUREAU

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10099

CERTIFICATE OF DEATH

10105

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Marys		STATE Maryland		COUNTY St. Marys			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hermansville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hermansville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10				STREET ADDRESS (If rural give location) Rural			
3. NAME OF DECEASED (Type or Print) Thomas Frederick Hopewell				4. DATE OF DEATH (Month) 10 (Day) 25 (Year) 1955			
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Feb. 12, 1888		9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School janitor		10b. KIND OF BUSINESS OR INDUSTRY State of Md.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hopewell				14. MOTHER'S MAIDEN NAME Maria Chase			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 218- 07-2011		17. INFORMANT & ADDRESS Agnes P. Hopewell- Hermansville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) Chronic Myocarditis						INTERVAL BETWEEN ONSET AND DEATH 3 years	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1, 1950, to Oct 25, 1955, that I last saw the deceased alive on Oct 15, 1955, and that death occurred at 8 P.M. from the causes and on the date stated above.							
SIGNATURE <i>John H. Patrich</i>		M.D. <i>Lexington Park Md.</i>		DATE SIGNED <i>10-27-55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 10/28/55		NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		LOCATION (City, town, or county) Great Mills, Maryland.	
24. REC'D BY REGISTRAR DATE 10/27/55		REGISTRAR'S SIGNATURE <i>P. J. Beary M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>C. B. Robinson - Leonardtown Md.</i>			

CERTIFICATE OF DEATH

Form No. 10-1-1

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAN 10 1955		BALTIMORE, MD.	
AGE		SEX		RACE	
65		M		W	
MARRIED		OCCUPATION		EDUCATION	
Y		LABORER		8	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
HEART DISEASE		NATURAL		CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
J. H. HARRIS		J. H. HARRIS		JAN 10 1955	
LOCAL HEALTH OFFICER		COUNTY HEALTH OFFICER		STATE HEALTH OFFICER	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED
JAN 10 1955
BALTIMORE, MD.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10:00

CERTIFICATE OF DEATH

10106

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Medley's Neck</u>		<u>6 yrs.</u>		TOWN <u>Rural Medley's Neck</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>William</u> (Middle) <u>Ernest</u> (Last) <u>Knott</u>				<u>10/</u> <u>19/</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>11/3/1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farm</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>213-22-1335 William E. Knott Medley's Neck, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1 <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary sclerosis</u>						<u>8 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 17, 1955</u> to <u>Oct 19, 1955</u>, that I last saw the deceased alive on <u>Oct 19, 1955</u>, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>P. J. Bean</u>		<u>Oct 20/55</u>		<u>Quietville, Md.</u>		<u>Oct 20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/22/55</u>		<u>St. John's</u>		<u>Hollywood, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct 20/55</u>		<u>P. J. Bean</u>		<u>Jos. C. Mattingley</u>		<u>Leonardtwn, Md.</u>	

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10108

10101

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Hollywood		40 yrs.		TOWN Hollywood			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) George (Middle) Franklin (Last) McKay				(Month) Oct. (Day) 21 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	September 17, 1872	83 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farming		Farm		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Mitchell McKay				Mary Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		NONE		Manning McKay Leonardtown, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 420.1 Coronary occlusion						is known	
ANTECEDENT CAUSE(S) DUE TO (B) General arteriosclerosis						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cholecystitis						6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work Not while at work		21i. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Oct 21, 1955 , to Oct 21, 1955 , that I last saw the deceased alive on Oct 21, 1955 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
M. Sean				West Mills Md		10/22/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
BURIAL		10/24/55		St. John's		Hollywood, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Oct 24/55		M. Sean		Joe C. Mattingly		Leonardtown, Md.	

10108

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DEATH RECORDING NUMBER OR RECORDING

2. NAME OF DECEASED

Hollywood

NO. 1234

Hollywood

35

3. DATE OF DEATH

4. PLACE OF DEATH

5. SEX

6. RACE

7. DATE OF BIRTH

8. MARRIAGE

9. OCCUPATION

U.S.A.

10. RESIDENCE

11. CAUSE OF DEATH

12. MANNER OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF

18. SIGNATURE OF

BUREAU V. 2

OCT 25 1955

RECEIVED

Hollywood, Maryland

10/25/55

10/25/55

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10107
10102 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>St. Mary's</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>St. Mary's</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chaptico</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chaptico</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<i>Barbara Williamson Miles</i>		<i>Oct 4 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>Aug. 4 1955</i>
9a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <i>none</i>		9b. KIND OF BUSINESS OR INDUSTRY: <i>none</i>	
10a. BIRTHPLACE (State or foreign country): <i>Maryland</i>		10b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. FATHER'S NAME: <i>George Fredrick Miles</i>		12. MOTHER'S MAIDEN NAME: <i>Grace M. Nelson</i>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		14. SOCIAL SECURITY No.: <i>George F. Miles Chaptico, Md.</i>	
15. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>571.0</i>		
Immediate cause (a) <i>Diarrhea</i>		
Antecedent causes (s) (b) <i>none</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>none</i>		

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Oct. 3, 1955*, to *Oct. 4, 1955*, that I last saw the deceased alive on *Oct. 3, 1955*, and that death occurred at *9:05 A.M.* from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>		<i>10-6-1955</i>	<i>St. Joseph</i>	<i>Morgantown</i>	<i>Md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR			
<i>10-4-1955</i>	<i>P. J. Bean</i>	<i>Joe E. Mattingly Leonardtown Md.</i>			

4085222374

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10103

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10109

Reg. Dist.

No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Colorado</u>		COUNTY <u>unknown</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Lexington Park</u>		LENGTH OF STAY (in this place) <u>3 mo.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Fort Collins</u> <u>44 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital Patuxent River, Md.</u>				STREET ADDRESS (If rural, give location) <u>1601 North College Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Loren Dale Moody</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10 - 24 - 19 55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>11 - 1 - 1924</u>	9. AGE last birthday: <u>30</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country): <u>Wyoming</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>E.N. Moody</u>				14. MOTHER'S MAIDEN NAME: <u>Amy Williamson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY No.: <u>12/12/42 to 10/24/55</u>		17. INFORMANT & ADDRESS: <u>Official Navy Records</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p><u>976X</u> Immediate cause (a) <u>Penehring bullet wound of brain</u> DUE TO</p> <p>Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Lexington Park, St. Marys, Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10 24 55 6 AM.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>self inflicted with own revolver</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . SIGNATURE <u>[Signature]</u> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/26/55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Transportation</u>		DATE THEREOF <u>10/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Local</u>		LOCATION (City, town, or county) (State) <u>Jackson, Wyoming</u>	
DATE REC'D BY LOCAL REG. <u>10-27-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>P.B. Robinson - Leonardtown, Maryland.</u>			

RECEIVED

NOV 2 1965

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10104 Items 2,5, Film 187 10-10-55 et
CERTIFICATE OF DEATH

10110

Reg. Dist. No. 282

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St. Mary's</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>St. Mary's</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Leonardtown</u>		TOWN <u>Helen</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
78 <u>St Mary's Hospital</u>		-----	1
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Infant Morgan</u>		<u>Oct 2 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Oct 4 1955</u>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		9B. AGE last birthday: <u>1</u> yrs. <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. FATHER'S NAME: <u>John N. Morgan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S MAIDEN NAME: <u>Rachel Samton</u>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		15. SOCIAL SECURITY No. <u>-----</u>	
16. INFORMANT & ADDRESS: <u>John N Morgan Helen, Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
762.5 IMMEDIATE CAUSE (A) <u>Respiratory arrest</u>			8 hours.
ANTECEDENT CAUSE (S) DUE TO (B) <u>Immaturity, Prematurity</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE LAST STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Oct. 1, 1955</u> to <u>Oct 2, 1955</u> , that I last saw the deceased alive on <u>Oct. 1, 1955</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Joseph E. Gill</u>		ADDRESS <u>Leonardtown, Md.</u> DATE SIGNED <u>10/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/3/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) <u>Morgans, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/3/55</u>		24. FUNERAL DIRECTOR <u>John S. Mattingly</u> ADDRESS <u>Leonardtown, Md</u>	

20062 10-10-55

RECEIVED

OCT 4 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10105

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 282

10111

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN Rural Mechanicsville		18 yrs.		TOWN Rural Mechanicsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) Gertrude (Middle) Agnes (Last) Owens				(Month) Oct. (Day) 17 (Year) 19 55			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: January 27, 1894	
9. AGE last birthday: 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Home		9. AGE last birthday: 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: William Wathen				14. MOTHER'S MAIDEN NAME: Sarah Morgan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Moses Owens Mechanicsville, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) Arterio-sclerosis Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO						10 yrs.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION: none				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH none		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY none		21c. (City or town) (County) (State) none			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY none		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		21f. HOW DID INJURY OCCUR? none			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> SIGNATURE [Signature] CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/18/55 M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: 10/19/55		NAME OF CEMETERY OR CREMATORY: St. Joseph's		LOCATION (City, town, or county) (State): Morganza, Md.	
DATE REC'D BY LOCAL REG. 10-18-55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR: Jos. C. Mattingley		ADDRESS: Leonardtwn, Md.	

RECEIVED

OCT 19 1955

BUREAU V. S.

10106

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St Mary's</u>	MARYLAND	STATE <u>Delaware</u>	COUNTY <u>New Castle</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Patuxent River, Md.</u>	LENGTH OF STAY (in this place) -----	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lexington Park Claymont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Station Hospital, U.S. Naval Air Station, Patuxent River, Md.</u>	STREET ADDRESS <u>8307 Tower St.</u> <u>-295 Chinlee Drive (see birth cert.)</u>		
3. NAME OF DECEASED: (Type or Print) <u>Cindy</u> <u>Lou</u> <u>Reese</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct</u> <u>22</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>10-21-55</u>
9. AGE last birthday: ----- yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>John R. Reese</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Ann Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		17. INFORMANT & ADDRESS: <u>John R. Reese Address: same as # 2</u>	
16. SOCIAL SECURITY NO. -----		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Prematurity, Neonatal death</u>			<u>1 hr. 35 m.</u>
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-21</u> , 19 <u>55</u> , to <u>10-22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>55</u> , and that death occurred at <u>1230A</u> M. from the causes and on the date stated above.			
SIGNATURE <u>LTJG R.J. IRONS MC USNR</u>		DATE SIGNED <u>10-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		NAME OF CEMETERY OR CREMATORY <u>Claymont, Delaware</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-24-55</u>		REGISTRAR'S SIGNATURE <u>John R. Reese</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Patuxent River, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES OF AMERICA

BUREAU V. S.

OCT 26 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10113

Reg. Dist. No. 282

10107

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Marys		MARYLAND		STATE District of Columbia			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Leonardtwn		14 hrs.		TOWN Washington		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
78 St. Marys Hospital				1421 -19th Street S.E.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
William Leonard Stevens				10/ 31 / 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	married	Feb. 19, 1900	55 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Auto Mechanic		Temple Motors		Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Temple Stevens				Elizabeth Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		577-16-0137		1421-19th St. S.E. Cecelia M. Stevens- Washington, D.C.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
540.0 IMMEDIATE CAUSE (A)				Intestinal hemorrhage			
ANTECEDENT CAUSE(S) DUE TO				Bleeding Meckel's diverticulum			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				or stomach ulcer			
STATING UNDERLYING CAUSE LAST. DUE TO (C)				14 hrs			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10:30 , 19 55 , to 10:31 , 19 55 , that I last saw the deceased alive on 10:30 , 19 55 , and that death occurred at 6 A .M, from the causes and on the date stated above.							
SIGNATURE Frank Mink				DATE SIGNED 10.31.55			
M.D. Lernard Mink				ADDRESS (Street, city, town, state) 1661 Good Hope Rd. S.E. Wash. D.C.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11/2/55		Fort Lincoln Cemetery		Bladensburg, Maryland.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 10/31/55		Alan D. Housery		Benjamin B. Davis			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10108

CERTIFICATE OF DEATH

10114

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Marys		MARYLAND		STATE Maryland		COUNTY St. Marys	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Callaway		27 yrs		TOWN Callyway		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				Rural			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) James (Middle) -- (Last) Thompson				10 - 29 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	colored	married	May 7, 1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
farming		farm owner		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Thompson				Sophia Briscoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		-----		Nellie B. Thompson, Callaway, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary thrombosis				INTERVAL BETWEEN ONSET AND DEATH 2 months			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. General arteriosclerosis				6 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not white at work <input type="checkbox"/> White at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1955 to Oct 29, 1955 , that I last saw the deceased alive on Oct 28, 1955 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) [Signature]			
DATE Oct 30/55				DATE SIGNED 10/30/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11/2/55		St. Georges Cemetery		Valley Lee, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
[Signature]		[Signature]		[Signature]		Leonardtwn, Md.	

